PROVIDER: _____ UNIT: _____ DATE: _____

RANK/GRADE: _____ Last 4 of SSN: _____ CATEGORY (circle): CG PHS CIV-GS CIV-CONTR DOD AUX

REQUEST OF CLINICAL PRIVILEGES (CG-5575C)
PHYSICAL THERAPIST

PHYSICAL THERAPY CORE PRIVILEGES

Examination, consultation, evaluation, and treatment of all age group patients with neuromusculosketetal symptoms referred by other health care practitioners

Tests, therapies, and procedures: Provide initial and subsequent evaluations; establish physical therapy assessment, plan of treatment per accepted therapeutic standards of care per the Guide to Physical Therapy Practice guidelines.	
Perform initial evaluation, assessment and establish treatment plan of patients with neuromusculoskeletal symptoms per SMO guidance. Tests of strength, balance, coordination, endurance, and gait Range and quality of motion Ultrasound, Phonophoresis Electrotherapy Iontophoresis Thermal therapy Cryotherapy Hydrotherapy: including superficial wound debridement and dressing changes	Exercise therapy Gait training Activities of daily living/functional training Manual therapy to peripheral joints Soft Tissue Mobilization Apply manual therapy to spinal joints Fitting and fabrication of: - prosthetics, orthotics, supports, splints, and shoe orthoses

PROVIDER: _____ UNIT: _____ DATE: _____

CLINICAL PRIVILEGES- PHYSICAL THERAPY (continued)

PROVIDER: _____ UNIT: _____ DATE: _____

SUPPLEMENTAL PRIVILEGES

* SUPPLEMENTAL PRIVILEGES ** (Original Initials Required)	PT Requesting	SMO Recommendation Approve	 Disapprove	CG 112/PM Recommendation Approve	 Disapprove
Request appropriate diagnostic radiologic studies (shall be interpreted/reviewed by a Physician)	____	_____	_____	____	____
Prescribe non-narcotic analgesics and nonsteroidal anti-inflammatory drugs (NSAIDs) as delegated by the SMO. (to be filled only at the facility's pharmacy)	____	_____	_____	____	____
Other:_____	____	_____	_____	____	____

☐ Check Box if NO supplemental privileges are requested

SMO's ADDITIONAL RECOMMENDATIONS/RESTRICTIONS:

** Providers requesting supplemental clinical privileges will be required to submit additional documentation supporting training and education.*
***Original initials required on each line of requested supplemental. An "X" or a "√" will not be accepted.*

PROVIDER: _____ UNIT: _____ DATE: _____

CLINICAL PRIVILEGES- PHYSICAL THERAPY (continued)

PROVIDER: _____ UNIT: _____ DATE: _____

REVIEW AND SIGNATURES

PRACTITIONER REQUESTING PHYSICAL THERAPY PRIVILEGES:

SIGNATURE _____ DATE: _____

SENIOR MEDICAL OFFICER: _____ DATE: _____

CHIEF HEALTH SERVICES DIVISION: _____ DATE: _____
** CG-112 Program Manager will sign BELOW if CHSD is same as the requesting provider.

CG-112_PROGRAM MANAGER : _____ DATE: _____

COMMENTS: _____
_____

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CHAIRPERSON, PROFESSIONAL REVIEW COMMITTEE:
SIGNATURE: _____ DATE: _____

DIRECTOR, HEALTH AND SAFETY:
SIGNATURE: _____ DATE: _____